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MEDICARE AND THE BUY-IN PROCESS

Medicare (Title 18 of the Social Security Act) is a health program administered by the Health Care Financing Administration. Coverage is available to nearly everyone over 65 and those who have been receiving Social Security Benefits as disabled for 24 consecutive months..

Medicare is a two-part program. Part "A" provides hospital, hospice and skilled nursing facility benefits. It is available without charge to individuals who have worked a certain number of quarters where FICA deductions are mandated. People who are not eligible automatically, may enroll by paying a monthly premium.

Part "B" is optional medical insurance for which everyone enrolling must pay a monthly premium. Most individuals pay the same amount but when enrollment in Part B is postponed, individuals pay a different rate. There is a 10% increase in the premium for each year of delay in enrolling in Medicare Part B. Part "B" assists in payments for doctors, outpatient hospital care, therapy, ambulance and laboratory services.

Both parts of Medicare have deductibles and coinsurance charges which are the responsibility of the individual, although private insurance plans may be purchased which cover these payment gaps.

The following groups of individuals and couples are provided with additional benefits by Medicaid when enrolled in Medicare:

	Payment of Part A	Payment of Part B	Payment of Ded. & Co-Ins.
SSI and State Supplement Recipients		X	X
Pickle Amendment		X	X
Qualified Medicare Beneficiaries (QMB)	X	X	X
Qualified Disabled and Working Individual (QDWI)	X		
Specified Low Income Medicare Beneficiaries (SLMB)		X	
Qualifying Individuals (QI) Part 1		X	

Qualifying Individuals (QI) Part 2

The only benefit for Qualifying Individuals (QI) Part 2 is:
one time annual payment of \$12.84 for 1998, \$26.76 for 1999.

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The state payment for Part "B" premiums is accomplished through a computer process called the "buy-in". There is usually a delay between the time an individual is eligible for the buy-in and the time the buy-in begins. During this time, the individual continues to have the Part "B" premium deducted from their Social Security check. Once the buy-in begins, the individual receives the gross Social Security Benefit and is reimbursed for the Part "B" premium collected during any delay period.

Appendix (3-1)

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CALCULATIONS FOR SUBSTANTIAL GAINFUL ACTIVITIES (SGA)
AND IMPAIRMENT RELATED-WORK EXPENSES (IRWE)

To compute SGA earnings and costs of certain items and services needed to work and related to medical impairment will be deducted from the monthly average gross earnings. These costs are allowable even though the items and services are also used for daily living needs in addition to work, unless otherwise stated below. The costs for each item must be the responsibility of the disabled individual. Actual or potential reimbursements from another source will be an amount if the individual reduce the allowable deduction.

<u>EXAMPLE:</u>	Individual purchases crutches for	\$80
	Reimbursement from another source	<u>64</u>
	Allowable cost	\$16

I. ALLOWABLE EXPENSES FOR CONSIDERATION

- A. Attendant Care Services - Only that portion of cost associated with assistance
 - 1. traveling to and from work.
 - 2. with personal functions while at work (such as eating, toilet.
 - 3. with work related functions (such as reading, communicating).
 - 4. with personal functions at home for work (such as dressing, administering medications).

NOTE: Attendant care services may be paid to a family member only if that person suffered an economical loss by ending this job or other employment in order to perform these services. The family member can be related by blood, marriage, or adoption, and need not live with the disabled person.

- B. Medical Devices - This item includes durable equipment (such as canes, wheelchairs, crutches).
- C. Prosthetic Devices (such as artificial limbs).
- D. Work Related Equipment specifically designed to accommodate an impairment (such as typewriters and telecommunication devices for deafness).

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E. Residential Modifications:

1. Outside - For individuals employed away from home, changes may be made to the outside of the home to permit transportation to work. (such as the installation of an exterior ramp for a wheelchair confined person or special railing or pathways for a person requiring crutches).
2. Inside - If an individual is employed at home, costs of modifying the inside of the home is allowed to create a work space to accommodate the individual's impairment. Only those expenses associated directly with the work area will be allowed, (such as the enlargement of the doorway leading to the work area).

NOTE: If the cost can be deducted as a business expense for the IRS, then it CANNOT be deducted in this calculation.

- F. Non-medical Appliances and Equipment - Appliances and equipment specifically prescribed by a physician as essential for control of the impairment. Essential means the item must be one that if not available would cause immediate adverse impact on the individual's ability to function in work activity. (such as the need for an electric air cleaner for an individual who has severe respiratory disease and must work in a purified air environment).
- G. Drugs and Medical Services - including diagnostic procedures to control medical impairments. These items must be prescribed or utilized to reduce or eliminate symptoms of the impairment or to slowdown its progression. The diagnostic procedures must be performed to ascertain how the impairment is progressing or to determine what type of treatment is needed. (such as anticonvulsant drugs for epilepsy, antidepressant drugs for mental disorders, radiation treatments or chemotherapy for cancer patients). Items or services not directly related to the impairment are not allowable deductions (such as routine annual physical exams, optician services when the impairment is not visual, and dental checkups).
- H. Medical Supplies - Medical items utilized for work and directly related to the impairment. (such as catheters, bandages, irrigating kits and face masks).

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I. Transportation - Payments for transportation are limited to the following:

1. Own Vehicle:

- i. If the individual's impairment necessitates a modified vehicle needed for travel to work, modifications must be critical to the individual's operation or use of the vehicle and directly related to the impairment. The cost of the modifications is deductible but not the cost of the vehicle.
- ii. If the impairment prevents use of public transportation to and from work, a physician must verify that the need to drive is caused by the impairment and not the lack of public transportation.
- iii. A mileage allowance of 25 cents will be given for the trip to and from work and also, if needed, the cost to hire a driver.
- i. Hired Transportation - Actual payments made to hire a driver will be allowed but not a mileage allowance.

Exception: Except for mileage and modifications, costs for the operation of any vehicle are not allowable.

J. Installation, Maintenance and Repairs - Costs directly associated with these services for all appliances or devices which qualify as a deduction in this appendix.

B. LIMITS ON DEDUCTIONS

Expenses must be incurred on or after December 1, 1980 and the payments made during a month when the individual was working. An individual is considered working even if absent from work temporarily to receive medical treatment. With contractual agreements made prior to 12-1-80 payments made as installments after 12-1-80 are allowable deductions.

In addition, a portion of payments for certain items made in any of the eleven (11) months preceding a month of work, can be made.

NOTE: Allowable deductions in anticipation of work are limited to durable items such as medical devices, prosthesis, work related equipment, residential modifications, non-medical appliances

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and vehicle modifications, as defined in Section A above. Payments for services and expendable items such as drugs, oxygen, diagnostic procedures, medical supplies, and vehicle operating costs are not deductible for purposes of determining payments in anticipation of work.

For recurring expenses, payments made on a regular periodic basis, on credit and paid in installments, or rental, may be used.

For non-recurring expenses the one time payment may be deducted in one month or over a 12 consecutive month period beginning with the month of payment.

For down payments a separate deduction process is possible which may be prorated for up to a year. The proration may be for a shorter time period if the regular monthly payments are extended over a period of less than 12 months. When this happens, the proration time period for the down payment and duration of the regular monthly payments will be the same.

EXAMPLE:

Individual begins to work on March 1, 1990 and at the same time purchases special equipment which costs \$4800, giving \$1200 down. The balance of \$3600, plus interest of \$540, is to be repaid in 36 installments of \$115 per month beginning April 1, 1990.

\$1200	Down payment	3/90
<u>1265</u>	Monthly payments	
\$2465	÷ 12	= \$205.42

A monthly deduction of \$205.42 would be allowed. After February 1991, the deduction changes to the regular monthly payment of \$115 per month.

Before any payments are used as deductions against SGA, the amounts must be determined reasonable.

Amounts up to the prevailing charges for durable medical equipment, prosthetic devices, medical services, and similar medically-related items and services as set by Medicare will be allowed. If the individual pays more than the prevailing charge allowed under Medicare it will be allowed if he or she can establish that the average is consistent with normal charges within their community.

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EXAMPLE:

Mr. Adams applies for Medicaid based on his disability. His assets are below \$2000. His income consists of Social Security benefits of \$132.90 gross and part time earnings of \$530 gross a month.

After determining that the job was not created out of sympathy, a hobby, or part of therapy or Vocational Rehabilitation training, the presence and value of impairment related work expenses must be considered.

Mr. Adams is currently paying for a special shoe made from a mold and which costs \$682. He has been making \$50 payments monthly after an initial \$100 down payment in March 1991 when he also found employment.

Using the policy under down payments, the calculation for the pretest is:

$$\begin{array}{r} \$100 \quad \text{Down payment} \\ \underline{582} \\ \$682 \end{array} / 12 = \$56.83 \quad \text{Monthly payments over one year}$$

As an allowable Impairment Related-Work Expense:

$$\begin{array}{r} \$ 530.00 \quad \text{Gross wages} \\ - \quad 56.83 \quad \text{IRWE} \\ \hline \$ 473.17 \end{array} \quad \begin{array}{l} \text{Compare to earnings allowable standard.} \\ \text{(see Example to calculate eligibility.)} \end{array}$$

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PICKLE AMENDMENT

In order to be considered under this amendment all of the following criteria must be met:

- I. There must have been concurrent entitlement to both SSI or State Supplement and Social Security benefits no earlier than 4-1-77. Concurrent entitlement can occur without concurrent receipt. Usually entitlement to Social Security benefits occurs the month prior to receipt of the first Social Security check.
- II. The individual or couple must be current recipients of Social Security benefits.
- III. The reason for closure of SSI benefits can be for any reason.
- IV. If there is a spouse, with Social Security benefits used in the deeming process, the COLA of the spouse may also be disregarded even if the spouse does not qualify for PICKLE status. This disregard applies only when using the SSI income standard as the criteria.

When these conditions are present, all COLA's since the last loss of SSI or the State Supplement (but not prior to 7-77) will be disregarded from monthly countable income as the last step in that process.

Individuals or couples who are categorically eligible, without using this disregard, are not eligible under the Pickle Amendment.

As an additional benefit, the State of Maine will pay the Medicare Part B premium of Pickle individuals or couples. (see Appendix 3-1)

Once an individual or couple is covered under this group, each additional COLA is disregarded along with the initial increase to determine continued eligibility.

Individuals or couples remain in this group until ineligible due to other SSI criteria, such as no longer living in Maine, increase in assets, increase in income from another source, or change in living arrangements.

Individuals and couples may lose coverage under this group and later regain it. Continuous eligibility is not necessary.

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EXAMPLE:

This demonstrates one reason why an individual was ineligible after the first COLA but was eligible 1 year later after the next COLA. The cause for this is a change in other allowable disregards. Other factors may cause the same result, such as use of IRWE, loss of earnings or loss of other income.

Mr. Tom Keys' SSI was closed when he became entitled to Social Security benefits. A review was completed to determine Medicaid coverage.

\$ 420.40	Gross income
- 20.00	Federal disregard
<u>\$ 400.40</u>	
- 42.30	State disregard eff. 1/86
\$ 358.10	> Categorical standard (\$346.00 eff. (1/86)

This determination placed Tom in a deductible for 10/86 - 3/87. In December a COLA desk review was done with a 1.3% increase.

\$ 420.40	Gross income
x 1.013	COLA increase
<u>\$ 425.87</u>	
	Rounded to \$425.90

\$ 425.90	Gross income
- 20.00	Federal disregard
<u>\$ 405.90</u>	
- 42.30	State disregard
\$ 363.60	> Categorical standard (\$346.00)
- 5.50	COLA increase
\$ 358.10	> Categorical standard (\$346.00)

The Pickle Amendment did not change the outcome so the deductible was updated.

In January 1988 Mr. Keys reapplies:

\$ 425.90	Gross income
x 1.042	COLA increase
<u>\$ 443.79</u>	
	Rounded to \$443.80

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\$ 443.80	
- 20.00	Federal disregard
<u>\$ 423.80</u>	
- 55.00	State disregard
<u>\$ 368.80</u>	> Categorical standard (\$364.00)
- 23.40	Pickle disregard \$5.50 eff. 1987 and
<u>\$ 17.90</u>	eff. 1988
\$ 345.40	< Categorical standard (\$364.00)

This results in eligibility eff 1/88.

One of the problems that may arise during calculation of this disregard results when all the prior Social Security benefits needed are not available through old records of the Third Party Query Printout (TPQY). However, using the following formula and chart, the COLA's can be determined when only one benefit amount is confirmed.

$$\frac{\text{Current Gross Benefit}}{1 + \text{COLA increase \%}} = \text{previous gross benefit}$$

COST OF LIVING ADJUSTMENT TO SS BENEFITS

<u>Check received month/year</u>	<u>Percent of Increase</u>	<u>New Medicare</u>
7-77	5.9% or 1.059	7.60
7-78	6.5% or 1.065	8.20
7-79	9.9% or 1.099	8.70
7-80	14.3% or 1.143	9.60
7-81	11.2% or 1.112	11.00
7-82	7.4% or 1.074	12.20
DELAYED		
1-84	3.5% or 1.035	14.60
1-85	3.5% or 1.035	15.50
1-86	3.1% or 1.031	15.50
1-87	1.3% or 1.013	17.90
1-88	4.2% or 1.042	24.80
1-89	4.0% or 1.040	31.90
1-90	4.7% or 1.047	28.60
(33.90 Jan-Apr) 29.80 reimbursement		29.90
1-91	5.4% or 1.054	29.90
1-92	3.7% or 1.037	31.0
1-93	3.0% or 1.030	36.60

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COST OF LIVING ADJUSTMENT TO SS BENEFITS cont.

Check received month/year	Percent of Increase	New Medicare
1-94	2.6% or 1.026	41.10
1-95	2.8% or 1.028	46.10
1-96	2.6% or 1.026	42.50
1-97	2.9% or 1.029	43.80
1-98	2.1% or 1.021	43.80
1-99	1.3% or 1.013	45.50
1-00	2.5% or 1.025	45.50
1-01	3.6% or 1.036	50.00
1-02	2.6% or 1.026	54.00

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EXAMPLE:

Check received 10-82 shows a benefit amount of \$182. The gross would be \$12.20 more to account for Medicare.

$$\frac{194.20}{1.074} = 208.571 \text{ or } \$209$$

In 1981 Medicare was an even \$11.00.

This method is not fault free because the Social Security Administration has changed the rounding off rule several times in recent years. The method will be off if the individual receives benefits based on a spouse or parent's earnings record. Also, if a change in benefit type took place, such as the individual is receiving benefits from a living spouse who dies, changing the claim type to widow benefits.

If correction of prior eligibility for Medicaid is needed, to determine how far back to start a Medicare buy-in, refer to the standards below:

INDIVIDUAL			COUPLE	
FEDERAL	STATE		FEDERAL	STATE
20.00	42.30	alone	20.00	64.40
	44.30	with others		67.40
	44.30	household of another		67.40

DATE

4-77	177.80	alone	266.70
	175.80	with others	266.70
	119.87	household of another	177.80
7-77	187.80		281.70
	185.80		278.70
	126.54		189.80
7-78	199.40		299.10
	197.40		296.10
	134.27		201.40
7-79	218.20		327.30
	216.20		324.30
	146.80		220.20
7-80	248.00		372.00
	246.00		369.00
	166.67		250.00

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7-81	274.70	412.00
	272.70	409.00
	184.47	276.67
7-82	294.30	441.40
	292.30	438.40
	292.30	438.40
7-83	314.30	471.40
	312.30	468.40
	312.30	468.40
1-84	324.00	487.00
	322.00	484.00
	322.00	484.00
1-85	335.00	503.00
	333.00	500.00
	333.00	500.00
1-86	346.00	519.00
	344.00	516.00
	344.00	516.00
1-87	350.00	525.00
	348.00	522.00
	348.00	522.00

INDIVIDUAL		COUPLE	
FEDERAL	STATE	FEDERAL	STATE
20.00	55.00	20.00	80.00

7-87	350.00	alone/others	525.00
	348.00	household of another	522.00
1-88	364.00		547.00
	362.00		544.00
1-89	378.00		568.00
	376.00		565.00
1-90	396.00		594.00
	394.00		591.00
1-91	417.00		625.00
	415.00		622.00

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	Individual		Couple
1-92	432.00	alone/others	648.00
	430.00	household of another	645.00
1-93	444.00		667.00
	442.00		664.00
1-94	456.00		684.00
	454.00		681.00
1-95	468.00		702.00
	466.00		699.00
1-96	480.00		720.00
	478.00		717.00
1-97	494.00		741.00
	492.00		738.00
1-98	504.00		756.00
	502.00		753.00
1-99	510.00		766.00
	508.00		763.00
1-00	523.00		784.00
	521.00		781.00
1-01	541.00		811.00
	539.00		808.00
1-02	555.00		832.00
	553.00		829.00

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OTHER COVERABLE GROUPS STILL IN FEDERAL LAWINDIVIDUALS OR COUPLES WHO WOULD HAVE LOST AID TO THE AGED, BLIND OR DISABLED (AABD) COVERAGE SOLELY DUE TO AN INCREASE IN SOCIAL SECURITY BENEFITS IN AUGUST, 1972

Individuals or couples must have been receiving or eligible to receive AABD in August 1972, and must have received an increase in Social Security Benefits in August 1972. Individuals or couples who would have been eligible for AABD except that they were residing in an institution are also included in this section. If the individual or couple would be eligible for SSI after disregarding the increase in Social Security, the individual or couple is eligible for coverage as Categorically Needy.

INDIVIDUALS WHO WERE ELIGIBLE AS "ESSENTIAL SPOUSES" IN DECEMBER 1973

The individual must have been living with a recipient of the Aid to the Aged, Blind or Disabled (AABD) program in December 1973 and receiving Medicaid at that time. "Essential Spouse's needs must have been used to determine the amount of the AABD grant." In order to continue Medicaid for the "essential spouse", the former AABD recipient must continue to be eligible for an SSI payment and the needs of the "essential spouse" must continue to be included in determining the payment to the SSI recipient.

INSTITUTIONALIZED INDIVIDUALS WHO WERE ELIGIBLE IN DECEMBER 1973

The individuals must have been eligible for Medicaid in December 1973 as inpatients of medical institutions or intermediate care facilities that were participating in the Medicaid program. The individual must continue to meet Medicaid eligibility requirements in effect in December 1973, continue to reside in the institution and be classified as needing institutionalized care.

BLIND AND DISABLED INDIVIDUALS WHO WERE ELIGIBLE IN DECEMBER 1973

The individuals must meet all current Medicaid eligibility criteria except those for blindness or disability and must have continued to meet all criteria for Medicaid, including blindness and disability, in effect in December 1973.

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LIFE ESTATE AND REMAINDER INTEREST TABLES

Age	Life Estate	Remainder	Age	Life Estate	Remainder
0	.97188	.02812	44	.89221	.10779
1	.98988	.01012	45	.88558	.11442
2	.99017	.00983	46	.87863	.12137
3	.99008	.00992	47	.87137	.12863
4	.98981	.01019	48	.86374	.13626
5	.98938	.01062	49	.85578	.14422
6	.98884	.01116	50	.84743	.15257
7	.98882	.01178	51	.83674	.16126
8	.98748	.01252	52	.82969	.17031
9	.98663	.01337	53	.82028	.17972
10	.98565	.01435	54	.81054	.18946
11	.98453	.01547	55	.80046	.19954
12	.98329	.01671	56	.79006	.20994
13	.98198	.01802	57	.77931	.22069
14	.98066	.01934	58	.76822	.23178
15	.97937	.02063	59	.75675	.24325
16	.97815	.02185	60	.74491	.25009
17	.97700	.02300	61	.73267	.26733
18	.97590	.02410	62	.72002	.27998
19	.97480	.02520	63	.70696	.29304
20	.97365	.02635	64	.69352	.30648
21	.97245	.02755	65	.67970	.32030
22	.97120	.02880	66	.66551	.33449
23	.96986	.03014	67	.65098	.34390
24	.96841	.03159	68	.63610	.36369
25	.96678	.03322	69	.62086	.37914
26	.96495	.03505	70	.60522	.39478
27	.96290	.03710	71	.58914	.41086
28	.96062	.03938	72	.57261	.42739
29	.95813	.04187	73	.55571	.44429
30	.95543	.04457	74	.53862	.46138
31	.95254	.04746	75	.52149	.47851
32	.94942	.05058	76	.50441	.49559
33	.94608	.05392	77	.48742	.51258
34	.94250	.05750	78	.47049	.52951
35	.93868	.06132	79	.45357	.54643
36	.93460	.06540	80	.43659	.56341
37	.93026	.06974	81	.41967	.58033
38	.92567	.07433	82	.40295	.59705
39	.92083	.07917	83	.38642	.61358
40	.91571	.08429	84	.36998	.63002
41	.91030	.08970	85	.35359	.64641
42	.90457	.09543	86	.33764	.66236
43	.89855	.10145	87	.32262	.67738

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88	.30859	.69141
89	.29526	.70474
90	.28221	.71779
91	.26955	.73045
92	.25771	.74229
93	.24692	.75308
94	.23728	.76272
95	.22887	.77113
96	.22181	.77819
97	.21550	.78450
98	.21000	.79000
99	.20486	.79514
100	.19975	.80025
101	.19532	.80468
102	.19054	.80946
103	.18437	.81563
104	.17856	.82144
105	.16962	.83038
106	.15488	.84512
107	.13409	.86591
108	.10068	.89932
109	.04545	.95455

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Reserved.

(APA Office Note: Appendix A-1 was entitled "SPOUSAL ASSET ALLOCATION." Rev. 131 (effective October 1, 1995) was written in part to replace it. Rev. 137 (effective January 30, 1996) states this explicitly.)

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#198ASTATE OF MAINE
DEPARTMENT OF HUMAN SERVICESTo: _____ Case No: _____

CONSENT DECISION

On or about _____ a hearing was requested on behalf of (applicant) _____ to appeal the allocation of spousal assets.

Both (applicant & spouse) _____ and the Department agree to the following:

(applicant) _____ resides in a nursing facility and applied for Medicaid on _____.
(applicant's spouse) is the community spouse.

As indicated below, (applicant's spouse) can keep \$ _____ of the couple's countable assets effective _____.

INCOME ALLOWANCE

\$ _____ monthly mortgage/rent	\$ _____ Minimum Income Allowance
+ _____ real estate taxes	- _____ community spouse's gross income
+ _____ condo fees	(less interest income)
+ _____ home owners insurance	\$ _____ deficit in meeting monthly income
+ _____ utility standard	allowance
\$ _____	
-436 (30% of \$1,452)	
\$ _____ Excess Shelter Expense	
+ 1,452 Minimum Income Standard	
\$ _____ Monthly Income Allowance	
(may not exceed \$2,232)	

Average cost of an annuity to generate \$ _____ per month income is \$ _____.

Dated _____ Signed _____ (Supervisor)
for the Department of Human Services

Dated _____ Signed _____
Institutionalized spouse or representative

Based upon the agreement between the parties, this CONSENT DECISION to the Fair Hearing requested in this matter is the final agency action on the appeal.

Dated _____ Signed _____
Hearing Officer

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Below is a list of Supplies and Equipment provided to recipients by a Nursing Facility as part of regular rate of reimbursement:

The following items may not be billed by either the facility or supplier. Facilities which service a special group of the disabled are expected to furnish that equipment which is normally used in their care (e.g. children's wheelchairs) as a part of their reasonable cost.

Routine supplies and personal care items which are provided by the Nursing Facility under 67.05-11(A), may not be purchased by a resident and then deducted from their cost of care. The Nursing Facility must provide any brand name item to the resident as part of the Nursing Facility regular rate of reimbursement if the resident has a therapeutic need as documented by the physician.

1. Alcohol, swabs and rubbing
2. Analgesics: (non-prescription): 1) Acetaminophen: tablets, 325 mg, 500 mg; liquid; suppositories, 325 mg, 650 mg. 2) Aspirin: tablets, 325 mg, plain, buffered, coated; suppositories, 325 mg, 650 mg.
3. Antacids: aluminum hydroxide, magnesium hydroxide: gel and tablets (ex. Maalox). 2) Aluminum/magnesium hydroxide with simethicone (ex. Mylanta, Maalox Plus). 3) Calcium carbonate tablets (ex. Tums). 4) Calcium carbonate/magnesium hydroxide tablets (ex. Roloids).
4. Alternating pressure pads, air mattresses, "Egg crate" mattresses, gel mattresses
5. Applicators
6. Bandages
7. Band-aids
8. Basins
9. Beds (standard hospital type, not therapy beds)
10. Bed pans
11. Bed rails
12. Blood pressure equipment
13. Bottles (water)
14. Canes
15. Calcium supplements: 1) Calcium carbonate (ex. Tums). 2) Calcium carbonate with vitamin D (ex. Oscal).
16. Catheters
17. Catheter trays (disposable)
18. Chairs (standard, geriatric)
19. Combs
20. Commodes
21. Corner chair
22. Cotton
23. Cough syrup & expectorants: (non prescription) 1)Guiafensin (ex. Robitussin). 2)Guiafensin - DM (ex. Robitussin DM) 3) Ammonium chloride/diphenhydramine (ex. Benylin).
24. Crutches

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25. Cushions (e.g., comfort rings)
26. Dietary supplements
27. Disinfectants
28. Douche trays (disposable)
29. Dressings
30. Enema equipment
31. Enteral feedings, supplies and equipment
32. Facility deodorants
33. Gauze bandages (sterile & unsterile)
34. Glucometers
35. General services such as administration of oxygen and related medications, hand feeding, incontinency care, tray service and enemas
36. Gloves (sterile)
37. Gloves (unsterile)
38. Gowns
39. Hemorrhoidal preparations
40. Ice bags
41. Incontinent supplies full brief - all sizes; bed pans; undergarment liners, disposable or reusable; under pads.
42. Iron supplements (oral: ferrous sulfate; ferrous gluconate; liquid and/or tablet)
43. Irrigation trays
44. Laundry services, personal (including supplies and equipment)
45. Laxatives: Stool softeners: docusate sodium liquid or capsule. Bulk: psyllium. Stimulants: Bisacodyl tablets and suppositories; docustae casanthranol, liquid and/or capsule. Enemas: saline; phosphate types (ex. Fleets); oil retention. Misc.: Milk of Magnesia; glycerin suppositories; lactulose and analogs (when used as a laxative); mineral oil.
46. Lotions (emollient)
47. Lubricants (skin, bath oil)
48. Mouth wash
49. Ointments and creams (available over the counter), including petroleum jelly and hydrocortisone 0.5%
50. Ophthalmic lubricants: tears, ointments
51. Oxygen, for emergency and prn use only
52. Parenteral solutions, supplies and equipment
53. Pillows
54. Pitchers (water)
55. Powders (medicated and baby)
56. Prone boards
57. Rectal medicated wipes
58. Restraints (posey, thoracic chest supports, tilt in space chairs, wedge pillows, etc.)

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59. Shampoo: three types: 1) regular; 2) medicated; and 3) no tears - baby shampoo
60. Sheepskin
61. Shower chairs
62. Soap: include one hypoallergenic type
63. Special dietary supplements
64. Specimen containers
65. Sterile I.V. or irrigation solution
66. Stethoscope
67. Sunscreen - level 30
68. Supplies (non-prescription) necessary for the treatment of decubiti
69. Suture sets
70. Swabs, medicated or unmedicated
71. Syringes and needles
72. Tapes
73. Testing materials to be used by staff or facility
74. Thermometers
75. Tissues
76. Toothbrush
77. Toothpaste - two types accepted by AFA; and a denture cleaner
78. Towels, washcloths
79. Tongue depressors
80. Traction equipment
81. Trapezes
82. Tub seats
83. Tubes (gavage, lavage, etc.)
84. Urinals
85. Urinary drainage equipment and supplies (disposable)
86. Vitamins: two brands acceptable to pharmacy and dietary
87. Walkers
88. Wheelchairs - standard, including those with removable arms and leg rests, pediatric, "hemi" chairs, reclining wheelchairs
89. Routine personal hygiene and grooming to include, but not limited to: shave, shampoo, bathing, nail clipping (unless specified as a covered service by a podiatrist in the Maine Medical Assistance Manual), unless the services of a barber or hairdresser are requested by and paid for by the resident
90. Routine transportation of residents or laboratory specimens to hospital or doctors offices

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APPENDIX 4-4**Transfers Taking Place Prior to 1/1/94 and Trusts Set Up Prior to 8/11/93**

These rules apply to transfers taking place prior to 1/1/94 and to trusts that are set up prior to 8/11/93.

TRUSTS

Trust funds are available assets unless the terms of the trust make them unavailable.

If the trust is irrevocable, that is, no member of the assistance unit or any responsible relative residing in the home has the power to revoke the trust arrangement or change the name of the beneficiary, what is available to the client is what is made available according to the terms of the trust.

1. The terms of the trust may specify the amount/frequency and or purposes for which the funds may be used or this may be left to the discretion of the trustee(s). The terms of the trust may use a combination of both trustee discretion and specific fund usage.
2. Of the funds left to trustee discretion, what is available to the client is whatever the trustee makes available.
3. Funds made available are considered as income or assets in accordance with applicable Medicaid eligibility rules for the situation.
4. If the terms of the trust restrict withdrawal by written approval of a judge of the courts, regular withdrawals will be treated as any other income. Irregular withdrawals, in order to be disregarded, must be used to supplement the needs of the person for whom the trust is drawn up.

EXAMPLES:

1. An individual has a trust fund that was established upon the death of his parents based on their will. From this he is to receive \$500 from the interest each month and \$10,000 every three years to buy a new vehicle. The monthly payments are income. The \$10,000 is used to purchase an excluded asset (the old vehicle is traded in to purchase the new one).

This trust is irrevocable in accordance with the provisions above. The terms of the trust specify the amount, frequency and for part of the payments (the \$10,000) the purpose. Medicaid policy treats interest payments as income and excludes the vehicle as an asset.

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2. A trust was set up for the individual by his father who is deceased. The individual is to receive \$200 per month for as long as the fund lasts. The fund currently has \$140,000. The individual can get all the funds in the trust if there is an emergency.

The \$200 per month is considered income as long as this represents interest income. The remainder of the fund is considered an asset (currently \$140,000) since it can be accessed by the individual.

3. A trust is set up for the individual by her grandmother. It is irrevocable and the trustee has full discretion in disbursement of the funds (totaling \$75,000) based on the needs of the individual.

Since the trust is irrevocable, what is considered available to the individual is whatever the trustee, in her discretion, makes available.

Medicaid Qualifying Trusts:

Even if a trust is irrevocable, it may be considered as an available asset if it meets certain conditions listed below. These are called Medicaid Qualifying Trusts. This is a type of trust or other legal device which

1. is established by the individual or individual's spouse (other than by will). It may be irrevocable or established for purposes other than to enable the grantor to qualify for medical assistance, and,
2. the individual is the beneficiary of all or part of the payments from the trust, and,
3. the distribution of such payments is determined by one or more trustees who are permitted to exercise discretion with respect to the distribution to the applicant.
4. when established by the individual's or spouse's legal guardian or power of attorney, the trust is considered to have been established by the individual or spouse whom they represent.

The amount of this trust that is counted as an asset is the total undistributed amount that is permitted under the terms of the trust that the trustee could disburse if he, as trustee, exercised his full discretion.

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Because Medicaid is the payer of last resort, it is expected that individuals (and their spouses) access available trust income and assets before turning to Medicaid. The assets and income from trusts that contain provisions that purport to limit the trustee's discretion to disburse funds in situations related to the individual's application for Medicaid are to be considered without regard to such provisions. For example, the assets and income of a trust are to be considered without regard to any provisions that purport to limit the trustee's discretion to disburse funds when the individual applies for Medicaid or enters a nursing home.

EXAMPLE:

Mary establishes a trust under which she is a beneficiary. The trustee has discretion to distribute all of the assets of the trust to Mary except if she applies for Medicaid or enters a nursing home. In those circumstances, the trust states that the trustee does not have discretion to disburse the funds to Mary. At the time Mary applies for Medicaid, the trust is valued at \$200,000. All of the \$200,000 is considered available to Mary.

Amounts actually distributed are counted as income and/or assets using applicable eligibility rules for the situation.

When determining eligibility for Nursing care assistance, the value of an irrevocable trust may constitute an uncompensated transfer of assets. See section 4120.

If the Department determines that denial of eligibility would constitute undue hardship, these provisions may be waived. The consequence of being denied Medicaid coverage by itself does not constitute undue hardship.

EXCEPTIONS:

- A. When the beneficiary of a trust is a mentally retarded individual who resides in an Intermediate Care Facility MR the trust is not considered a Medicaid qualifying trust provided the trust or initial decree was established prior to April 7, 1986 and is solely for the benefit of the mentally retarded individual.
- B. Trusts that are set up with retroactive SSI benefits awarded under the ZEBLEY vs. SULLIVAN decision are exempted from the provisions of the Medicaid Qualifying Trust and transfer of assets rules.

EXAMPLES:

- A. The individual's wife set up a trust fund for him before she died. The trust is irrevocable. The individual receives monthly payments of \$100 from interest accrued on the principal and the trustee may disburse the remaining funds (currently \$150,000) to meet living expenses.

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This is a Medicaid Qualifying Trust because it was set up by the individual's wife (not by will). Therefore, the total amount of the trust (\$150,000) is a countable asset. This is the total undistributed amount of the trust that the trustee could disburse if she exercised her full discretion.

2. Same as Example 1 except: Added to the monthly interest income of \$100, the remaining funds are disbursed in \$3,000 semi-annual payments for the life of the individual. Any funds remaining at his death are passed to the individual's daughter. The trustee has no discretion in the disbursement of funds.

Here, both the \$100 per month and the \$3,000 semi-annual payment are income. Since the trustee has no discretion in disbursement of funds, nothing else is countable.

3. The individual sets up a trust fund for himself that is irrevocable. He receives \$500 per month from interest. The principal will be donated to the Save the Whale Foundation at his death. The trustee has no discretion in disbursement of funds.

This is NOT a Medicaid Qualifying Trust even though it was set up by the individual other than by will for his benefit because the trustee has no discretion in distribution of the trust funds. The disbursement of \$500 per month are counted as income under the general rules applying to trusts.

ASSETS

Individuals must use their assets to meet their needs. Specific types and amounts may be retained by the individual and community spouse to meet current and future needs.

All available assets are to be used in determining eligibility. Countable assets are defined in Section 3300.

For individuals entering a nursing facility prior to 9/30/89 only the assets of the individual are considered in determining eligibility. Assets owned solely by the community spouse are not considered in the eligibility determination.

For individuals entering a nursing facility after 9/30/89 with a spouse living in the community, see Section 4130.

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COUPLES RESIDING IN A NURSING FACILITY

If the total assets of a couple in the same room in a nursing facility exceed the standard for a couple, one of the individuals may reapply for assistance. This results in one being an ineligible spouse. Beginning the first of the month after being denied, only the assets remaining in the name of the eligible spouse are considered when determining eligibility.

If the couple resides in different rooms in the same facility or in different facilities, then each is treated as an individual when determining the asset limit. Since there is no penalty for transfer of assets between spouses, they can decide who will retain the assets.

No spousal allowance of income or assets is determined since the ineligible spouse is not living in the community.

TRANSFER OF ASSETS

"Assets" are defined as cash or other liquid assets or real or personal property.

When determining eligibility for BME, BMR and ALPHA Waivers and nursing care services, the following applies to transfers to individuals by the applicant or the applicants spouse. Transfers between spouses do not incur a penalty. Although an individual or couple may be eligible in the community, once a request is made for waiver or nursing care services all assets must be checked back 30 months from date of application to determine if a transfer has occurred.

Transfers ONLY EFFECT nursing and waiver services, all other Medicaid services may still be covered.

To determine the effect that the transfer has on eligibility several questions must be answered:

- I. What was transferred?
- II. Who was the transfer made to?
- III. When was the transfer made?
- IV. What did the individual or couple receive in exchange?
- V. Why was the transfer made?

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EXEMPT TRANSFERS

The following may be transferred without penalty:

- I. The home if it is transferred to
 - A. a child who is under age 21 or who does or would meet SSI criteria of total and permanent disability or blindness.
 - B. a sibling who has an equity interest in the home and was residing in the home for at least one year prior to the individual going to the medical institution.

EXAMPLE:

A brother and sister have joint ownership of a home in which they both lived for the last 5 years prior to the brother going into a nursing facility. The brother may transfer his interest in the home to his sister without penalty.

A penalty would be established if:

- 1. the sister was not a joint owner or had no equity interest in the home, or
 - 2. the sister had not lived in the home one year prior to the institutionalization of her brother.
 - C. a child over age 21 who does not meet the SSI criteria of blindness or disability if the child was residing in the home for at least two years prior to the individual's entering the medical institution and was providing care which enabled the institutionalized individual to live at home rather than a medical institution for this time.
 - D. a spouse.
- II. Any asset transferred to the individual's child who does or would meet SSI criteria of total and permanent disability or blindness.
- III. Assets which the owner intended to dispose of at fair market value or for other valuable consideration but, without being at fault, the owner did not obtain full fair market value.

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- IV. Assets, exempt or non-exempt, transferred to (or for the sole benefit of) the community spouse.
- V. Assets transferred 30 months prior to the date of application.
- VI. Assets transferred for Fair Market value:

FAIR MARKET VALUE

A transfer for fair market value incurs no penalty. Fair market value may be received in cash. It may also be in the form of past support for basic necessities or past medical expenses and debts, if measurable and verifiable. A reasonable value must be placed on the support provided or medical costs and the specific time period for which it is given substantiated. Past support for basic necessities does not include such items as gifts, clothing, transportation or personal care provided by relatives unless these were provided as part of a legally enforceable agreement whereby the individual would transfer the asset or otherwise pay for such items.

Examples of transfer for fair market value:

- I. An individual transfers ownership of a life insurance policy to a funeral home.
- II. An individual's sister pays all household expenses while he waits for an insurance settlement of \$5000. He verifies that his rent, utilities and food came to \$4500. He may transfer the \$4500 to his sister without penalty because these are basic necessities which are measurable and verifiable.

Examples of transfers for less than fair market value:

- I. A couple sells their home to their son for \$40,000. The assessed value is \$70,000. A \$30,000 transfer has occurred.
- II. An individual has help from her daughter with shopping, cleaning and preparing meals. The daughter spends four to eight hours a week providing these services. When the individual enters a nursing facility she transfers \$25,000 to her daughter to compensate for these services. Since these were not provided as part of a legally enforceable agreement to pay for these services, the transfer does result in a penalty.

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- III. A neighbor comes in for an hour a day to help a couple prepare meals and do laundry. Two years later the couple give the neighbor \$50,000. Two months later they enter a nursing facility. Based on the average cost for homemaker services in the area a value of \$10.00 per hour is placed on these services and \$7280 of the transfer is allowed. The remaining \$42,720 would be a transfer for less than fair market value.

DISPROVING THE PRESUMED TRANSFER

Any transfer taking place will be presumed to have been made for the purpose of becoming or remaining eligible for Medicaid, unless the individual furnishes clear and convincing evidence that the transaction was for some other purpose and that there was no intent at the time to apply for Medicaid within the foreseeable future. It is the Department's responsibility to demonstrate that a transfer took place and to establish the date of the transfer. It is the individual's responsibility to prove that the transfer took place for reasons other than to gain eligibility for Medicaid.

If the individual wants to disprove the presumption that the transfer was made to establish Medicaid eligibility, the burden of proof rests with the individual. The individual must demonstrate that the transfer was specifically and solely for some other purpose than to receive Medicaid. Statements and evidence to disprove the transfer must be contained in the individual's record.

The statement should cover, but not necessarily be limited to the individual's:

- I. purpose for transferring the asset.
- II. attempts to dispose of the asset for fair market value.
- III. reasons for accepting less than the fair market value for the asset.
- IV. plans for and ability to provide financial support after the transfer.
- V. relationship, if any, to the persons to whom the asset was transferred.
- VI. belief that the fair market value was received.

In addition to the individual having to prove that the transfer was made specifically and solely for a purpose other than to be Medicaid eligible, other factors to be considered include

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- A. a sudden onset of a disability or blindness after the asset was transferred.
- B. the diagnosis of a previously undetected disabling condition after the transfer occurred.
- C. unexpected loss of other assets following the transfer.
- D. unexpected loss of income after the transfer occurs.
- E. court ordered transfers.

ESTABLISHING DATE AND VALUE OF A TRANSFER

I. Assets other than bank accounts:

A transfer of assets occurs on the date when

- A. title (ownership) or legal interest to property has passed from the individual or spouse to another individual.
- B. title to property has been given by establishing joint ownership, such as adding a name to stocks, bonds, real property.

The value of the transfer is the value of the asset or the part of the asset that is transferred. For example:

- 1. Sole ownership of a home valued at \$100,000 is transferred to another. The value of the transfer is \$100,000.
- 2. Sole ownership of a home valued at \$100,000 becomes jointly owned with another person. The value of the transfer is \$50,000.
- C. a document has been signed and delivered by the individual or spouse to another individual to transfer title at some future date. This concept does not include a will but does include a signed but unregistered deed.
- D. the asset is converted from an accessible to an inaccessible asset. An example is when assets are placed in an irrevocable trust or a name is removed from a jointly owned asset.
- E. the individual or spouse refuses to accept items which would be countable assets.

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I. Bank accounts:

With bank accounts, a transfer of funds in an account is determined to take place when:

- A. funds, owned by the individual, are withdrawn by the other joint owner(s) from an account and used for other than the sole benefit of the individual.

or

- B. another person's name is added to the individual's account, the money in the account is owned by the individual, and the intent of the individual in giving access is to convey ownership of those funds.

1. If the individual maintains that there was an intent to transfer funds in the bank account at the time a joint name was added, this intent must be documented.

Documentation consists of a clearly written statement of intent to transfer the funds in the account to the joint owner. This statement must be:

- i. a notarized statement
- ii. signed by the individual at the time the account was made joint or within a reasonable period of time, usually 1 week but maybe longer due to circumstances beyond the control of the client.

NOTE: Evidence of an intent to transfer the funds in the account at the time that the name was added to the account will be rebutted by evidence that the individual continued to use the funds.

EXAMPLE #1:

George adds his son Larry's name to a \$50,000 bank account in 8/91. In 6/92 Larry withdraws \$50,000 which he used to make renovations on his (Larry's) home. George is applying for nursing care services 9/92.

- a. Whose money is the \$50,000?

The money in the account is made up of deposits by George. This is George's money and there is a potential transfer.

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- b. What was George's intent of adding son's name?

If the intent was to convey ownership of the funds in the account, this must be documented with a notarized statement by George. In this situation, there is no statement from George. No transfer occurred when Larry's name was added as a joint owner.

- c. The 6/92 withdrawal is then examined as a transfer. Since Larry used the \$50,000 that was withdrawn for other than the sole benefit of George, a transfer has occurred. Unless the transfer is exempted (4120.01), the penalty is assessed for \$50,000 as of 6/92.

EXAMPLE #2:

Sally adds her son's name (Sam) to her bank account in 12/88. At that time there was \$70,000 in her account. At the time of adding her son's name to the account she signs a statement that she intends to transfer the funds in the account. Subsequently, Sally cashes a check for \$10,000 from the account. Also during the transfer penalty period, Sam cashes a check for \$20,000 from the joint account. At the time Sally applies for nursing care services in 9/92, there is \$40,000 in the account.

- a. The \$20,000 spent by Sam was a transfer subject to penalty. This is because Sally's continued use of the funds in the account rebuts her written statement saying she intended to transfer the funds to her son at the earlier time. Since the funds were Sally's when Sam cashed the check for \$20,000, this is a transfer subject to penalty.
- b. The \$40,000 remaining in the account is considered an available asset for Sally.

EXAMPLE #3:

Butch adds his nephew's name (Charles), to his (Butch's) solely owned bank account in 1/89. The \$70,000 in the account was owned by Butch. There is documentation that Butch intended to transfer the funds in the account at that time. In 5/92, Butch sells a piece of his solely owned property for \$20,000 and deposits this money in the joint account. Charles cashes a \$20,000 check from the account in 6/92. The account totals \$70,000 at the time Butch applies for nursing care services in 9/92.

- a. The \$20,000 withdrawn by Charles in 6/92 is considered to be part of the \$70,000 that Butch intended to give his nephew in 1/89. Therefore, this \$20,000 may not be subject to transfer penalty.

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- b. Of the remaining \$70,000 in the account:
- 1) \$20,000 is a countable asset for Butch since this \$20,000 was deposited by him from his funds.
 - 2) \$50,000 is owned by Charles due to the 1/89 transfer of funds.

ESTABLISHING A PENALTY

A period of ineligibility is imposed on the individual in a nursing care status if the individual or spouse disposes of an asset for less than Fair Market Value.

When a penalty is imposed, it is only the nursing care services that cannot be paid. The individual may be eligible for all other Medicaid services.

Once it has been determined that a transfer of assets has occurred for less than fair market value, the penalty period must be determined.

A special determination must be made for each transfer.

- I. Determine the date that each transfer occurred.
- II. Determine the amount of the transfer.
- III. Divide the amount of the initial transfer by the current average monthly private rate at the time of application for a semiprivate room rate for a nursing facility (see Chart IVc).

This determines the number of months of ineligibility based on the initial transfer. Any remaining fraction is to be disregarded. The penalty period may not exceed 30 months. The penalty period begins with the month in which the uncompensated transfer occurred. If there had been more than one transfer and a penalty is already in effect for that month, the penalty period will begin with the next non-penalty month.

EXAMPLES:

- I. An individual adds her daughter's name to her savings account on 4/14. A transfer for the entire balance has taken place. Based on the amount of funds in the account at the time of transfer she is ineligible for 7.3 months. Eligibility potentially begins 11-1.

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- II. An individual has a solely owned savings account with \$60,000 in it. In October 1992 he transfers \$60,000 to his daughter. He also owns stocks worth \$40,000 which he transfers to his son in December 1992.

10-92 \$60,000 divided by \$3619 = 16.5 months,
 potentially eligible 2/94
12-92 \$40,000 divided by \$3619 = 11 months,
 potentially eligible 1/95

The penalty on the 12/92 transfer does not start until 2/94. This is the first non-penalty month after the 12/92 transfer

In this case the individual is potentially eligible as of 1/95.

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APPENDIX A

PREPARATION FOR AND PARTICIPATION IN THE HEARING PROCESS

The purpose of a hearing is to review whether the Agency acted in accord with defined policy and procedural requirements in carrying out its actions. The review is usually requested in relation to proposed closings, denials, decreases in the level of coverage, and changes in deductible amounts. The hearing may also include questions of medical eligibility, classification for nursing care status and eligibility for retroactive coverage.

Hearings are not formal in the sense that there are oaths given, set formal procedures of addressing individuals concerned, or required procedures for entering objections or questioning at a particular time. Hearings are not casual conversations or arguments, however.

In addition to reviewing the decision itself, the Hearing Officer has the responsibility, at the hearing, to review whether appropriate procedures were followed in carrying out the action.

The Hearing Report

The agency representative has the responsibility to be prepared to give a report and to answer questions that may be asked by the Hearing Officer of other participants in the hearing. The Eligibility Specialist must make sure that proper written notice, with an advance notice period, if applicable, was forwarded to the applicant or recipient. The notice must cite the manual section on which the decision to deny or reduce benefits is based. It is not sufficient to state: "You have excess assets," or "You have excess income." The amount of assets or income should be given. In addition, the agency limit on assets or income should be cited. It might be necessary to cite more than one manual reference. If so, this should be done.

If the action results in a request for a hearing the Eligibility Specialist should submit a copy of the notice which was sent to the applicant or recipient to the Hearing Officer. The copy of the notice and other pertinent documents will become a permanent part of the Hearing Record.

When notified of a request for a hearing, the Eligibility Specialist must prepare a detailed report outlining what was done and why it was done. The report should indicate how the decision was made. If income is an issue, the Eligibility Specialist must elaborate on how net income was determined. If assets are an issue, the Eligibility Specialist must show what was considered as an asset. If medical eligibility is an issue, specifics should be given as to what went into the decision that the individual no longer is considered incapacitated or disabled in accord with agency policy. If the decision involved the Medical Review Team or AFDC Disability Specialist, contact must be made with that unit. The MRT or Disability Specialist will provide medical information if necessary.

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If negative action is taken because information is incomplete, inconclusive or conflicting, the Eligibility Specialist must show what is inconclusive and why more information is needed. The Eligibility Specialist also has responsibility to show that specific information was requested and that the individual was given the opportunity to resolve questions before action was taken.

A copy of the report is sent to the individual requesting the hearing by the Special Services Unit prior to the hearing. If the agency is informed that the individual has a representative for the hearing, a copy of the report is also sent to the representative.

To the extent that the report is complete and concise, it will assist the Hearing Officer in conducting the hearing and will assist the applicant or recipient in understanding or questioning information.

The Hearing

The Hearing Officer will begin the hearing by giving an opening statement. In the opening statement, the Hearing Officer will:

- I. cite the case name and basis purpose of the hearing;
- II. request the names of all present;
- III. remind all persons that the hearing is being recorded and that individuals should follow procedures by:
 - A. identifying themselves and referring to each other by name during the hearing;
 - B. make an effort to speak loud enough to be heard by all participants and face the recording equipment while talking.
- IV. Note that exhibits will be presented during the hearing.

After an opening statement by the Hearing Officer, the Eligibility Specialist will be asked to present a copy of the notice which was sent to the applicant or recipient.

The Hearing Officer will request a verbal report outlining the actions taken and the basis of the action. The report submitted by the Eligibility Specialist may be read or used as the basis for the verbal report. The Hearing Officer may ask additional questions if there are areas which are unclear. In addition, copies of documents such as medical statements, budgets, lists of assets or medical bills may be requested by the Hearing Officer. When requested, copies of these items should be given to the Hearing Officer and the individual requesting the hearing.

The individual or the representative may question the decision of the Eligibility Specialist. Questions should be made through the Hearing Officer and not between the persons involved.

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The individual requesting the hearing will be given the opportunity to:

- I. question any information;
- II. refute any information;
- III. present any additional information or make any comments.

In situations where additional information is presented, the Hearing Officer will decide whether the information had a bearing on the decision in question at the time of the decision or whether the information relates to a period of time subsequent to the decision. If the latter is the situation, the information should only be considered in a re-application or in carrying out a subsequent review.

After both parties have presented information and entered any questions and the Hearing Officer is satisfied that pertinent data has been presented, the Officer will summarize the issue as much as possible.

A continuance of the hearing may be determined by the Hearing Officer if additional data is needed, obtainable, and not available at the hearing. If the applicant or recipient requests a continuance, the Hearing Officer will determine if it would be appropriate.

The agency representative should always have manual material at the hearing and be prepared to cite necessary data from the manual.

Appeal

When the above procedures are followed and there is further appeal through the courts, those persons responsible for representing the agency have issues that are clearly defined. In addition, procedures such as adequate and specific notice may be raised in court even if not mentioned at a hearing. Thus, it is necessary that procedures taken, as well as the decision made, be reviewed at hearing.

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APPENDIX C

COMPUTATION OF UTILITY STANDARD

Utility Expenses:

The community spouse has the option of using the standard utility allowance (SUA) of \$401 per month or actual utility expenses as deductions. The must incur expenses for heating or air conditioning bills which are separate and apart from rent/mortgage or receive assistance from HEAP and ECIP in order to qualify for the SUA. At the time of redetermination and one additional time during each twelve month period, the community spouse may change the option between actual expenses and the SUA.

Standard Utility Allowance:

When expenses are incurred on an irregular basis, use the full SUA between billing periods. The full SUA can not be used for a community spouse who lives in a public or private rental unit which has central utility meters and charges the residents only for excess heating or air conditioning costs. If someone outside of the household is paying the entire cost of heating/cooling, and the payment is excluded as a vendor payment, the utility allowance is not allowed.

NOTE: Assistance from HEAP or ECIP automatically entitles the community spouse to the full SUA.

The SUA is not allowed when utility expenses are included in the rent unless the community spouse receives assistance from HEAP or ECIP, the residence is metered separately or the community spouse can otherwise provide verification that there are separate charges for heat and/or air conditioning.

Actual Utility Costs:

If the community spouse resides in public housing which has central utility meters and are charged only for excess utility costs, the excess amount incurred is allowed.

Whenever the SUA is not permitted, the community spouse may claim the actual expenses or elect to use the following individual standard if the expense is incurred:

cooking fuel and/or electricity (other than heat)	
water and/or sewer, trash collection	\$ 162.00
telephone	\$ <u>\$27.00</u>

Shared Residence:

To determine the utility allowance when the residence is shared by the community spouse and other persons, divide the appropriate utility allowance equally among the parties who pay for the cost. This prorated share is the utility allowance.

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Home Temporarily Vacated:

Shelter expenses can be allowed if the principle residence is temporarily vacated due to employment or training, illness, natural disaster or casualty loss ONLY if --

- I. the community spouse intends to return
- II. the home is not leased or rented while the community spouse is absent.

NOTE: Verification of actual utility cost for an unoccupied home is required if a deduction will be used. The SUA is not allowed for unoccupied homes.

Handling of Expenses Other Than Mortgage, Residence Insurance:

- I. Except when an expense is averaged, a deduction is allowed only in the month the expense is billed or otherwise becomes due, regardless when the community spouse expects to pay the expense. Amounts from past billing periods are not deductible.
- II. For an expense to be deductible, it must be payable to someone outside the household.
- III. Fluctuating expenses may be averaged. Expenses, which are billed less often than monthly, may be averaged forward over the interval between scheduled billings or if there is no schedule, over the period the expense is intended to cover. Interest, carrying charges, insurance, or penalties are not allowance expenses. Interest portions on mortgage payments are allowable.
- IV. That portion of the household shelter expenses associated with a business or trade is not considered as a deductible shelter expense.
- V. That portion of the shelter expenses paid by an excluded vendor payment shall not be allowed as a deduction. Shelter expenses paid via a countable vendor payment shall be allowed.
- VI. Shelter expenses shall be computed based upon expected expenses to be billed. Anticipation of the expense shall be based upon the most recent month's bills unless it is reasonably certain that a change will occur.

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- VII. Expenses billed weekly are converted by multiplying by 4.333 and those billed biweekly by 2.167 to obtain monthly figures.

Verification:

Utility expenses must be verified if the amounts claimed are in excess of the SUA and a deduction would result.

A move to a new residence requires reassessment of all shelter expenses.